THE

BOSTON MEDICAL AND SURGICAL JOURNAL.

VOL. LXIV. THURSDAY, APRIL 25, 1861. No. 12.

TWO CASES OF OBSTRUCTED VAGINA.

BY SAMUEL L. ABBOT, M.D.

[Communicated for the Boston Medical and Surgical Journal.]

SEVERAL years since, I was called upon, by an unknown lady, somewhere between 20 and 30 years of age, who said she wished to consult me about a peculiar difficulty, and to know whether it admitted of a remedy. After some hesitation, she said she thought she must be different from other women. She had been married but a few months, and her experience during that time had been one of so much suffering that she had at last made up her mind to consult a physician. She accordingly applied at the Massachusetts General Hospital, having it under consideration to enter that Institution as a boarder, if it were deemed expedient.

It being evident that there must be something abnormal about the sexual system, an examination was asked and somewhat reluctantly permitted. Everything about the external organs was natural, but on introducing the finger within the vagina and passing it towards the uterus, its progress was suddenly arrested, towards the upper part, by a transverse diaphragm or partition. This was extended across from one side to the other, and had nothing of the character of a contraction or an adhesion of the opposite walls. In its centre was a circular opening, so far as could be judged by the touch, which readily admitted the tip of the forefinger, and without much difficulty that of the ring-finger also. Above this diaphragm, say from three quarters of an inch to an inch, the os uteri was felt, apparently in a normal condition, surrounded by the *cul de sac* of the vagina, of its usual dimensions. The membranous partition had a very firm, inelastic feel, and, as far as could be judged by the finger, was at least an eighth of an inch in thickness. It was very rigid. Considerable force was used by separating the tips of the fingers, to determine if it was in any degree distensible or could be lacerated. No impression was produced upon it, and the effort caused considerable pain. Here was a serious obstacle to sexual intercourse, and the patient stated

that every act was attended by intense suffering, the whole of the neighboring parts being dragged upon and forced upwards in the most painful manner. It was evident that such an obstacle would be somewhat serious, should the lady become pregnant, at the time of labor; as its very unyielding character would probably require surgical interference to remove it, and a sudden rupture might lead to an injury of the vagina; it was altogether too firm to be trusted to the laceration which an advancing head might produce.

The patient was accordingly advised to submit herself to treatment for the removal of the obstacle at once. She left, promising to consult with her husband on the subject, and never returned. Perhaps her case may have fallen subsequently under the eye of some other physician, and it would be interesting to know what was the final issue of it. It should be added that the patient was not aware of having at any time sustained a local injury which could account for the existing state of things, nor was she, previous to her marriage, conscious of its existence. In fact, the character of the partition was not that of an inflammatory adhesion, or the result of any mechanical injury.

CASE II.—*Imperforate Hymen at the time of Labor.*—Mrs. ——, in labor with her first child. On making the first examination, not suspecting anything abnormal, a little embarrassment was momentarily felt in tracing the topography of the parts. The finger did not readily enter the vagina, but passed beyond it in an awkward way, suggestive of unprofessional bungling, not at all flattering to one's *amour propre*. A little more care, however, on a second essay, led to the discovery of an unruptured hymen. There was a small central opening in this membrane, which admitted the tip of the forefinger, and taking advantage of the presence of a pain, it was gradually worked through by a little pressure, without much opposition from the patient, until the uterus was reached, and the presentation made out. The patient was at once assured that there was no serious obstacle to the birth of the child, and that all things would issue well. This gave her great relief, as she said the apprehension of serious consequences had been a heavy burden on her mind for a long time, as she knew there was something wrong about her, but delicacy had prevented her speaking about it. As the hymen was not very firm, it was allowed to wait for the advancing head to come down upon it. As labor progressed, and the vagina became more and more relaxed, the orifice in the membrane was observed to be gradually dilating, until it was about an inch across, and the membrane itself had become proportionately thin. At last, as the head pressed upon it, the stretched edge was felt to give way under the finger by gradual rents at different points, like a piece of wet paper, without the consciousness of the patient, and the obstacle was removed. On subsequent inquiry of the husband, it was learned that the barrier had been a sufficiently embarrassing one, preventing entirely

complete coitus, but, as events proved, not enough to prevent impregnation; one of those facts, by the way, which overturn entirely the theories of those who argue that fruitful congress can only occur by the apposition of the orifice of the urethra to the os uteri at the moment of sexual orgasm, in which it is contended that the female must also of necessity participate. Such cases show conclusively that it is not necessary to suppose any *power of suction* in the uterus at that moment to introduce the spermatozoa within its cavity, and that their power of rapid movement is not altogether a superfluous endowment. The patient has had a second child since, and it was found at the time of labor that the occlusion had not been reproduced. A.

TABULAR STATEMENT OF DEATHS ATTRIBUTED TO THE EFFECTS OF INHALED CHLOROFORM.

By C. T. Jackson, M.D.

[Communicated for the Boston Medical and Surgical Journal.]

Chloroform was discovered in 1831 by Dr. Soubeiran, and by Liebig and Dumas in 1832. It was first proposed as a substitute for ether, by Mr. Waldie, at the request of Dr. Simpson, of Edinburg, in the month of December, 1847. Meanwhile etherization had been adopted by all civilized nations, from Europe to China, and was most extensively employed in surgery, and with great success.

Chloroform superseded ether, chiefly in some of the larger cities of Europe, and had not been used long before the world was alarmed by reports of numerous cases of deaths resulting from the inhalation of this powerful agent.

In 1850, Dr. E. F. Bouisson, of Montpellier, published the following table of deaths produced by inhalation of chloroform, showing the dangerous character of that "substitute for ether." These tables are sufficiently full to make the matter quite clear, and further comment is unnecessary.

We add, also, a table of the deaths following the employment of this anæsthetic agent in this country. It is not probable that it represents half the actual number that have occurred, our means of collecting such statistics being so imperfect in this country.

Since our committee, now having in charge the collecting of the statistics of etherization, to ascertain whether or no there have been any cases of death from the effects of ether, is still engaged in its labors, I shall abstain for the present from any remarks on that subject, and await the presentation of the report to the Boston Society for Medical Improvement. In the mean while, I shall continue my physiological and chemical investigations on the effects of ether on the humam organism.

TABLE *of Deaths attributed to the influence of Chloroform. Translated from "Traité de la Méthode Anœsthétique," of* E. F. BOUISSON, *Paris,* 1850 (*p.* 397–8), *by* C. T. JACKSON, M.D.

	Facts, Name of Surgeon, &c.	*Name and Condition of Patient.*	*Duration of Chloroformization and nature of Operation.*	*Epoch and Character of Death.*
1	M. Meggison, 1848.	Hannah Greener, age 15 yrs., great dread of inhalation of Chloroform.	Chloroform inhaled fr. handkerchief. Insensibility in half a minute, removal of a nail begun.	Immediate death in spite of all remedies given.
2	M. Pearson, 1848.	Mrs. Simmond, age 35 years, good health, tho' nervous; copious repast.	Chloroformization for some instants, after wh. some roots of teeth were extracted.	Death two minutes after commencement of inhalation.
3	A surgeon of Hyderabad, 1848.	A young woman having a lesion of left medius.	Inhalation of one drch. Chloroform from a handkerchief. Commenced amputation of the finger.	Immediate death.
4	Robinson, Dentist, 1848.	Walter Badger, age 23 years, had disease of heart and hypertrophia of liver.	Chloroformization from apparatus one minute. Operator absent ¾ min. to get bottle of chlorof.	Died during absence of the operator, who attempted in vain, by various remedies, to resuscitate the patient.
5	M. Gorré, of Bologne sur Mer, 1848.	Mad'lle Stock, age 30 years, having been subject to palpitation and chlorosis. Abscess following superficial wound on thigh.	Inhalation of Chloroform less than one min. This time sufficed to produce grave symptoms, during which the purulent sac of the thigh was opened.	Immediate death.
6	M. Robert, 1848.	Daniel Schlyg, age 24 years. Thigh broken by a ball in the days of June; profound depression, physical and moral.	Inhalation of Chloroform during 3 or 4 min. Disarticulation coxo-femoral; new inhalation of Chloroform.	Death during the operation.
7	M. Malgaigne, 1848.	Wounded in June, having the neck of the humerus broken by a ball; weakened by hæmorrhage, gangr. of wound.	Chloroformization; disarticulation scapulo-humeral; new inhalation while searching for the ball.	Death during last incisions.
8	Hotel Dieu of Lyon, 1848.	Charles Desnoyers, 22 years of age. Scrofulous, had white swellings of left hand.	Chloroformization with apparatus during five m. Cauterization of joint.	Death on commencement of operation.
9	Roux, in the Hotel Dieu of Paris, 1848.	Woman with scirrhous breast.	Chloroformization; amputation of the breast.	Death before leaving the operating room.
10	Reported by M. J. Guérin, Bicêtre, Sept. 1848.	Man with lesion of thigh.	Chloroformization; disarticulation coxo-femoral.	Death before end of operation.
11	M. Gordon Buck, New York, 1848.	Man weakened, having lesion of the heart, as proved by autopsy.	Chloroformization; excision of hæmorrholds.	Sudden death just as operation was about to commence.
12	Case of Govan, London Lancet, 1849.	Young person.	Chloroformization; removal of in-grown nail.	Immediate death.
13	M. Barrier, Lyon, 1849.	A glazier, 17 yrs. of age, scrofulous.	Inhalation of 6 to 8 grammes of Chloroform for six minutes, for amputation of a finger.	Convulsions, followed by death in half a minute.
14	Case in Hospital of Madrid, 1849.	Child 12 years of age.	Chloroform employed before amputation of leg.	Death during the operation, with violent tetanus.
15	M. Conferron or Langres, 1849.	Mad. Labrune, age 33 years, of nervous temperament.	Submitted a year before with success to inhalation of Ether. Submitted to Chloroform for extraction of a tooth.	Death as from a thunderbolt—"mort foudroyante."

A few cases of Death which took place during or immediately after the inhalation of Chloroform, in the United States. Compiled by CHARLES T. JACKSON, M.D., *Boston, March,* 1861.

	Authority.	*Name of Patient.*	*Nature of Anæsthetic Agent and Operation.*	*Death, &c.*
1	Coroner's Inquest. Dr. Charles H. Stedman, Med. Coroner. Autopsy by Dr. F. S. Ainsworth, Dr. C. H. Stedman and Dr. C. T. Jackson, Feb. 1855.	Phebe Ann Morgan, of Boston, a stout, healthy young woman. Case reported in Bost. Med. and Surg. Journal, by C. T. Jackson, M.D.	Chloroform inhaled preparatory to extraction of a tooth. Operation not performed.	Died in a few minutes before operation was begun. Stimulants and insufflation of lungs tried for resuscitation, without avail. Much chlorine and formic acid found in blood of heart, by chemical analysis.
2	Dr. Severence, Dentist, Salmon Falls, N. H.	Miss Packard, a healthy girl from Maine.	Chloroform inhaled preparatory to extraction of a tooth — the inhalation conducted by herself during the temporary absence of the dentist, and without his knowledge.	Found dead on return of the dentist, after a few minutes absence from the room.
3	Pawtucket Gazette.	Young girl, daughter of James C. Aldrich, of Pawtucket.	Chloroform inhaled by smelling of chloroform liniment, much of which was spilled in the bed near her face.	Died in half an hour. Stimulants tried for the purpose of reviving her, without avail.
4	Boston Traveller of April 8th, 1854.	Henry N. Dean, aged 21.	Chloroform inhaled for pleasure. Had often taken it for this purpose.	Died suddenly, in evening after the inhalation.
5	Boston Papers, June 4th, 1858.	Ebenezer B. Jones, a young man in good health.	Took an ounce and a half of Chloroform in water, as a remedy for seasickness while on a fishing party in the bay of Boston.	Complete stupor, followed by violent convulsions and death in an hour; remedies found of no avail.
6	Dr. Alden March, of Albany, N. Y. Trans. State Med. Soc. of N. Y., 1855, p. 159.	Miss Sarah Weaver, of Schoharie, N. Y., aged 18 years; in feeble state of health, from long disease. Operation done at the Albany N. Y. Hosp.	Large tumor in neck, involving carotid artery and jugular vein. Ether given first, then chloroform, and a very grave surgical operation was performed on her.	Sunk and died in two hours. Consulting surgeons attribute the death to loss of blood and nervous exhaustion. Probably chloroform hastened the death.
7	Dr. Davis, dentist, of Lynn, Ms.	Mary Farley, an adult married woman.	Chloroform and ether inhaled preparatory to extraction of a tooth.	Died in seven or eight minutes. Galvanism and other means employed to revive her, without effect.
8	Man in U. S. Marine Hospital, Chelsea. Dr. W. Ingalls.	Name not known to me.	Alcoholic solution of Chloroform, sometimes called strong chloric ether.	Sudden death before operation.
9	Man in Mass. General Hospital, Boston. Dr. J. C. Warren.	Name not now remembered by me.	Chloroform given by mistake for alcoholic solution of chloroform, inhaled from a sponge, preparatory to operation.	Immediate death in spite of free use of ammonia and other stimulants.

No. 6 is the only doubtful case in this collection. However, it is probable that the tendency to collapse and fatal result was partly due to the action of chloroform. Still, from its nature, the case might have terminated fatally, even if chloroform had not been administered.

C. T. JACKSON.

MEMOIR UPON CERTAIN POINTS IN THE ANATOMY AND PHYSIOLOGY OF THE MUCOUS MEMBRANE AND THE EPITHELIUM OF THE UTERUS DURING PREGNANCY.

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[Translated for the Boston Medical and Surgical Journal, by William Read, M.D.]

The investigations which are the subject of this work, have been made comparatively upon the human uterus, and those of divers of the domestic mammalia. I shall divide them into two portions, to facilitate the exposition of the subject; each of these will be subdivided, according to the nature of the particular points which I have to describe. In the *first part*, I shall treat particularly of the mode of connection, anatomical and physiological, of the placenta with the mucous membrane of the uterus, as well as of the structure of the latter, considered as a respiratory and nutritive organ for the fœtus.

In the *second part*, I shall describe the changes undergone by the epithelial coats of the uterus during pregnancy.

Part First.

OF THE MODE OF CONNECTION BETWEEN THE PLACENTA AND THE MUCOUS MEMBRANE OF THE UTERUS.

§ 1.—*Observations on the inter-utero-placental decidua.*—All authors are agreed in asserting that the inter-utero-placental decidua *(decidua serotina, membrane intermédiaire ou utero-epichoriale, placenta maternel)* is absorbed by the placenta, as the rest of the decidua is by the chorion. This fact is not, however, exactly true; and, to be comprehended, demands certain anatomical and physiological details.

We say, generally, that the villosities of the placenta (those of the lobes or cotyledons of the placenta) project into the sinuses of the decidua serotina, and are there immersed, and as it were floating; or that they are actually floating in the sanguineous lacunes *(lacs sanguins)* which represent these sinuses; that the blood is immediately in contact with the villosities of the chorion; that these villosities of the chorion, cotyledonal or placental, plunge into the decidua serotina, or into the sinuses in the same manner as the roots of a plant placed in the ground. This fact, nevertheless, is no more exact. The inter-utero-placental decidua is that portion of the uterine mucous membrane, at the surface of which, the villosities of the chorion become hypertrophied, to form the placenta. It separates the placenta from the muscular coat of the uterus.

In consequence of its situation, it is differently organized from the rest of the mucous membrane which becomes deciduous; this is so, under certain relations at least, and its life, and the manner of its behavior, are not identical. These differences of its organization depend upon its vascularity. The rest of the mucous mem-

brane of the uterus becomes *deciduous*, because its vascularity diminishes, and because, little by little, a new, thin, mucous membrane interposes itself under that which becomes deciduous; but, while this is taking place, we observe the portion of the mucous membrane which is *inter-utero-placental* become very vascular. Whilst the *uterine decidua* and the *decidua reflexa* are grayish, soft, thin, easy to tear, and to cut likewise; the *utero-epichorial* membrane is remarkable for its large sinuses nearly full of blood in the living, or full of bloody clots in the dead body. These veins, whose size has given them the name of sanguineous lacunes *(lacs sanguins)*, are directly continuous with the venous sinuses of the muscular coat, which are left very much larger just here than in the rest of the contractile parietes of the uterus. There results from the cut or dissected decidua serotina (inter-utero-placental decidua), a cavernous or erectile, areolar appearance, altogether peculiar. By cutting the large anastomosing canals in every direction in which they run, one is gradually led into the very substance of the muscular walls, traversed throughout by analogous sinuses; they are like them, with very thin walls, intimately adherent to the proper or muscular tissue of the uterus, and smooth on their internal surface. These sinuses terminate more or less abruptly at the circumference of the placenta, and that in a very plain manner, when, at the periphery of the latter, there exists among the membranes the *circular sinus* of the placenta with which they communicate. We know that this sinus is nothing else than one or more of these veins at the periphery of the inter-utero-placental decidua, varying generally in volume, according to the point at the circumference of the placenta which we examine. In making in a uterus, the placenta of which has not been detached, an incision involving the uterine decidua and the inter-utero-placental decidua, these two membranes present a very marked difference of aspect. The inter-utero-placental decidua appears like a very thick layer, pervaded by large vessels, which we do not see in the thinner decidua, properly so called.

This difference in thickness, it is true, is not very manifest except in an injected piece, or in one where the sinuses are filled with clots of blood, which last condition is rarely observed. It is due, in reality, to the existence of the sinuses already pointed out, and particularly to their distension by blood.

If, in the uterus of a woman dying pregnant at the seventh or ninth month, like that which in making this description I have under inspection (seven months and a half), we detach the placenta, we are struck with the following facts.

The chorion involves the *decidua uterina* and the *decidua reflexa*, which adhere to it and to each other; it detaches them from the contractile walls of the uterus, leaving the internal face of the muscular coat clothed with a mucous membrane of replacement, which has already begun to be developed. It forms a thin coat,

soft, more or less rosy, moulding itself upon the muscular fibres, and permitting them sometimes to be plainly seen when it is torn, or at least by transmitted light. The free surface of this commencing mucous membrane appears somewhat irregularly villous, when we study it under water. But in women who have died seven or eight days after delivery, it has already taken on a smooth surface, although its thickness may be as yet little augmented, and it is somewhat shiny, as if glutinous, but too soft to be separated by dissection from the subjacent coat. We see, besides, that the placenta carries with it the circular sinus which runs round its circumference, and which is slightly exterior to it, rather than inter-utero-placental, properly speaking. It carries with it, at the same time, the half, almost, of the substance of the *serotine*, or inter-utero-placental decidua, because it tears nearly through the middle of the sinuses which pervade this last everywhere; and yet it retains in this thin portion of inter-utero-placental decidua some portions of the sinuses still entire, particularly in the neighborhood of the circular sinus, and in the furrows or depressions which separate the uterine cotyledons. The placenta, also, when it separates from the uterus, does not carry away the inter-utero-placental decidua entire, as it does the rest of the uterine decidua. On the contrary, it leaves the greater part of it adherent to the uterus.

Here, then, are presented two subjects for investigation, and an observation full of interest:—1st, We have, on the one hand, the placenta with the chorion, which draws with it the uterine decidua and the decidua reflexa; but these membranes not offering anything to notice particularly, I shall not dwell on them any longer. 2d, On the other hand, we have the uterus, which, on the contrary, retains the entire vascular portion of the inter-utero-placental decidua, or at least two thirds of its thickness. I shall come back to that by and by; let us first look at the placenta.

§ 2.—*Of the adhering surface of the placenta after it has been detached from the uterus.*

The uterine face of the placenta exhibits embossments or projections of the cotyledons, separated by furrows more or less deep. But I am surprised that it has not been more carefully remarked, in an artificial separation of this organ in a woman dead before delivery, as well as in the placenta thrown off naturally, that the surface of the cotyledons is covered by a greyish membrane, semi-transparent, soft, and of a thickness of from a half to two millimetres ($\frac{2}{100}$ to $\frac{10}{100}$ of an inch) according to the subjects. This membrane is sometimes smooth and sometimes rough, and has an appearance altogether peculiar. It does not, any where throughout its substance, show vessels comparable with the circular sinus, which we frequently encounter at the periphery of the placenta, nor, as a matter of course, with the sinuses of the inter-utero-placental decidua. I have already pointed out, elsewhere, the important fact that this greyish membrane, rather elastic, and a little

viscous or glutinous also, passes without any break from one cotyledon to another, only showing a greater thickness in their interstices between which it dips.* This coat or membrane, detached from the inter-utero-placental decidua by the placenta to which it adheres, is represented by the thickened epithelium of this inter-utero-placental portion of the uterine mucous membrane, and by the most superficial portion of the inter-utero-placental decidua. And, besides, it is principally made up of epithelial cells, which have undergone considerable hypertrophy in their bodies and their nuclei, as well as distortions, often the most bizarre, modifications which I have elsewhere pointed out,† and to which I shall recur in the second paragraph of the last part of this memoir. Moreover, it encloses in this amorphous substance different molecular granulations, &c. We can also make out that at the periphery of the placenta, as we approach the decidua, it goes to continue itself with that portion of the latter which adheres to the chorion, rather than with the face of the decidua which has just been detached from the uterus.

The existence of this membrane which is constant, except when accidentally torn, demonstrates a very important fact, namely, that the villosities of the placenta do not dip freely and directly into the large sanguineous sinuses of the inter-utero-placental decidua. The cotyledons are very prominent on the side of the inter-utero-placental decidua, which, in its turn, dips to the bottom, not very deep for that matter, of the furrows which separate the cotyledons; but at the same time their substance, the ramifications of their villosities, every where pervaded by the fœtal blood, are separated from the blood, by this greyish membrane, whose thickness attains nearly two millimetres ($\frac{80}{1000}$ of an inch), and by the very thin membrane of the sinuses of the inter-utero-placental decidua. It is through the thickness of this coat and through that of the walls of the subdivisions of the villosities and their capillaries that, molecule by molecule, the change is made of nutritive matter from the mother to the fœtus and reciprocally. This transmission is far from being as direct as is thought, as any one can see; for the contact between the chorial or placental villosities is indirect—very indirect indeed.

The adhesion between the cotyledons is molecular, and very close, as we may see; since the placenta detaches the surface of the inter-utero-placental membrane, and carries that with it, rather than merely disengages itself from the latter; but it is no less true, that, from a physiological and an anatomical point of view also, the cotyledons, the placenta in a word, are simply applied to the surface opposite the great maternal vessels. They do not

* Ch. Robin, *Recherches sur les modifications graduelles des villosités du chorion et du placenta.*—(C. R. et Mem. de la Soc. de Biologie, Paris, 1854, in 8, p. 75.)

† C. Robin, *Memoire pour servir à l'Histoire Anatomique et Pathologique de la membrane muqueuse uterine, de son mucus et des œufs, ou mieux glandes de Naboth*, lu à la Société philomatique, le 18 Mars, 1848.—(*Archives generales de Médecine*, 4e series, t. xviii p. 201. Paris, in 8o.)

plunge in substance into the blood or into the tissue of the inter-utero-placental decidua, under the form of arborescent or radicular ramuscules, as all descriptions of them seem to point out, in which theory, the more easily to explain the endosmotic change, has certainly outrun observation.

§ 3.—*The connections between the Placenta and the Uterus, as seen in certain of the mammalia.*

I cannot refrain from making the remark, that the mediate and indirect connections of the placental villosities with the maternal vessels, constitute a fact that is not peculiar to the human species alone. It is not true, in reality, that the villosities of the cotyledons of the placenta or the chorion of mammals (such as ruminants, rodents, carnivora, solipedes, and fissipedes) dip, as we say, their terminal subdivisions in the tubular glands of the mucous membrane of the uterus, or in its dilated vessels.

In the rabbit, in particular, at the beginning of their evolution, the villosities penetrate between the folds of the uterine mucous membrane, which are full of vessels at this spot; but it is nothing else than an interlacing or entangling of these folds with the ramifications of the villosities, or at least with some of the ramuscular fibres. It is nothing, in the main, except a contiguity, on the one hand, of the ramifications, with the fold of a vascular mucous membrane on the other. This simple contiguity or application will become much more evident a little later, because it ends finally in being only very mediate.

In the same way, it is by an entanglement of the kind already pointed out, that the villosities of the cotyledons of the calf are connected by contiguity and adhesion with the uterine cotyledons of the cow; the latter are very vascular, but have no sinuses or sanguineous pouches, properly so called, for the arrangement of veins in the form of sinuses is seen nowhere except in the human female, or perhaps in those of the monkey tribe, whose uterus has a thick and firm mucous membrane, which is not intestiniform.

In reality, it is everywhere nothing but an application, face to face, as in the human female, of certain of the vascular portions of the fœtus and the mother, an application varying in the arrangements of their descriptive anatomy, if we may be allowed so to speak, according to the arrangement of the uterine mucous membrane, and the presence or absence of maternal cotyledons; but there is no trace of this penetration into the glands, of which we have spoken.

There are no other *utero-placental* vessels than those which run amongst these folds or projections of the mucous membrane of the uterus, which dip between the chorial or placental villosities of the mammalia mentioned before, and between the shallow sulci which divide the cotyledons of the placenta in man.

[To be continued.]

FOREIGN SUBSTANCE IN THE LARYNX.—TRACHEOTOMY.

By G. W. Chittenden, M.D., Janesville, Wis.

[Communicated for the Boston Medical and Surgical Journal.]

On the 13th of January, 1861, I was hastily called, in company with my friend, Dr. J. S. Lane, to visit Miss E. Holmes, a young lady of 15 years, who had a pin lodged at the base of the larynx. Her residence was four miles in the country. We reached there about 4, P.M. Before the accident, Miss H. was preparing for church, had just washed her neck, and was quite merry at the time. She came to her mother, requesting her to look at her neck, throwing back her head for the purpose, and at the same time inflating her lungs. A pin, in her mouth at the time, fell back into the pharynx, and passed into the air-tube. She immediately exclaimed, "A pin, a pin!" accompanied with violent efforts at coughing, and strangulation, with some retching. For an hour, she was almost in convulsions. When we arrived, being two hours after the occurrence, we found her in a great state of agitation, unable to speak, fearing to move a muscle, face bloated and livid, eyes congested, respiration nervously hasty, and her efforts at deglutition causing great pain. Whilst retching and coughing, much bloody mucus was ejected.

An immediate examination of the larynx and trachea was instituted, resulting in determining the locale of the pin, which occupied a position nearly transverse between the thyroid and cricoid cartilages, the point of the pin being to the left; by pressing the part between the thumb and finger, the pricking was felt by the patient at the left side, and the pain produced by pressure at the point would cause serious spasmodic movements.

In half an hour we had the patient placed on the table in a semi-recumbent position, the head thrown back to render the trachea prominent, and, with the aid of Dr. J. S. Lane, administered chloroform, and proceeded to an operation for the removal of the pin. It was begun by an incision commencing at a point immediately below the cricoid cartilage, and extending down an inch and a quarter, dividing the integument and superficial fascia. We then separated the sterno-hyroid and sterno-thyoid muscles, exposing the isthmus of the thyroid gland, which we next divided, bringing in view the trachea. The hæmorrhage being profuse, there was a necessity of stopping at different stages of the operation to ligate arteries. Four ligatures were applied, and yet the constant and profuse oozing of blood required a prolonged use of ice to entirely control the hæmorrhage, preparatory to making an opening into the trachea. With the pointed bistoury I punctured the trachea between the third and fourth rings, and, inclining the handle of the instrument downward about 45 degrees, carried the incision up to the cricoid cartilage, dividing the three upper rings, the edge of the instrument coming in contact with

the pin at the upper point of incision. Considerable bloody mucus was forcibly blown out at the opening. Passing up the forceps, I succeeded in getting hold of the pin, and in the effort to extract it the instrument lost its hold. This was followed by considerable excitement, much mucus being forced out at the opening and also from the mouth, with retching and vomiting. After the agitation had subsided, the forceps was again introduced, and not readily finding the pin, I passed in a probe, and after carefully exploring without being able to find its locality, decided to let her come out from under the influence of the chloroform, that we might avail ourselves of her sensations to elicit further information of its new location. Her first expression, after recovering from the anæsthetic influence of the chloroform, was, "It's gone; I don't feel it prick." As she was able to converse freely and audibly, to swallow liquids and fluids without pain, all pain having ceased, and none resulting from pressing on the larynx and trachea, we concluded the pin must have escaped with the mucous discharge. It was found in a mass of mucus on the carpet, bearing on it the mark from the edge of the bistoury. It is very nearly one and three-eighths of an inch in length.

The wound was closed with two sutures, and adhesive plasters, and arnicated water dressings applied.

14th and 15th. Aside from the nausea resulting from the use of chloroform, she has been very comfortable. Some slight disposition to cough remained for a few days.

On the 22d, the sutures were removed, and in two weeks from the time of the operation, she came to the office to have the wound dressed. At this date she is perfectly recovered.

CASE OF PROLAPSUS OF THE UMBILICAL CORD.

By E. A. W. Harlow, M.D., Boston.

[Communicated for the Boston Medical and Surgical Journal.]

I was lately called, at 9 o'clock in the morning, to a young lady in labor with her second child. The membranes had given way about fifteen minutes before I arrived. On examination, there was found in the vagina a coiled mass of the funis of about the size of a hen's egg. The os uteri was dilated to the size of a dollar, and dilatable, and the head above the superior strait.

In accordance with the mode adopted by some accoucheurs, in such cases, the patient was directed to get upon her elbows and knees, with her body across the bed, and to continue so during the occurrence of a few pains. When in this position, I passed my hand into the vagina, and pushed back first one portion of the cord, and then another, and so on, till the whole mass was returned and held, at the side of the head, by the tips of my fingers. When the next pain came on, the cord was pressed forcibly upon the ends of the fingers, but

prevented by them from passing out of the uterus; and the same pressure occurred during a few successive contractions. Gradually I pushed the cord a little higher, till, during one of the pains, when the head advanced, the cord did not advance with it, and was not felt. The patient was kept in the same posture till a few more pains had passed, but there was no re-appearance of the cord. She was then permitted to lie on her back, but the pains did not bring down the cord. The abdomen was then auscultted, and the fœtal tick of 140 a minute was distinctly heard. She was then allowed to leave the bed and pace the room, which she did without return of the prolapsus. All apprehension as to the result of the labor was now at an end. Every thing went on favorably, and at a quarter past two o'clock, in the afternoon, a living and vigorous child was born, weighing about ten pounds.

How far the position of the patient, favorable to the gravitation of the funis towards the fundus of the uterus, contributed to the successful result, I will not say. Perhaps any other posture would have answered as well. In that position, the first few contractions forced the cord against the tips of the fingers with as much power as if the patient were lying upon her back; so that position alone would not have sufficed. The head being above the brim was perhaps favorable; but there were needed the persistent efforts to keep the cord as far back as could properly be done.

TRIAL FOR MURDER BY POISONING.

(Continued from page 184.)

Charles T. Jackson.—Reside in Boston. Have been in practice as a physician. Am a consulting and analytic chemist and State Assayer. Have given attention to strychnia, in Paris and here. Have experimented myself. In solution, 1 to 2 grains has produced death in fifteen minutes. The extent of time depends upon the dose. Over a grain may kill a man in two hours. There occur spasms and violent contortions, spine is curved, hollow of foot arched. The flexor muscles are most acted upon, limbs most powerfully drawn up; then intervals of rest; then they come on again suddenly; oftentimes brought on by noise, or by contact with anything. When a glass of water is offered, it sometimes brings on convulsions, so that the patient snaps at the glass. These terminate with abundant cold sweats. If death occurs in spasms, muscles remain rigid, and body appears as if frozen. When death occurs in interval, the muscles, at first flaccid, become very soon rigidly tense and remain so for months after death, and do not give way until putrefaction begins. I know of no well-established exception. The one reported in Palmer's trial is doubtful. The patient can drink, but with great difficulty—the symptoms in that respect resembling hydrophobia. I never have known of a case where

a person poisoned by strychnia called for rum. I know of nothing which would exclude it. The patient might call for rum. It is common in intoxication from alcoholic drinks. The jaws are perfectly fixed, firm and rigid during spasm and after death. I think the neck could not be bent without raising the whole body.

Have witnessed the effects of strychnia upon warm-blooded animals; produced the same symptoms as in man. Spasms are produced in frogs from a great variety of causes. There is no comparison between the effect upon them and upon man. All poisons that affect them, do not affect man. The method proposed by Marshall Hall is to immerse frogs in a strychnia bath. Introducing it into the stomach is not Hall's method. It is not so delicate as applying it to the surfaces. It would not alter the taste of strychnia to dissolve it in liquor. No substance will dissolve strychnia so as to destroy its taste. I can't conceive of any person taking sufficient to destroy life, in solution, without knowing it; the taste is very bitter and persistent. The stronger the solution, the more decided would be the taste.

I have had a very extensive experience in *post-mortem* examinations. It is very common to find slight redness of surface of stomach. It is not uncommon to find redness of skin. Strychnia produces no such effect. In most cases of sudden death, the blood remains fluid, lungs engorged; common in sudden death to find distension of vessels of brain. I think it impossible, in case of death from strychnia, that the left ventricle should be gorged with blood.

I have heard the testimony of Drs. Hubbard and Davis. I don't think the *post-mortem* examination was complete. A portion of the liquid contents of the stomach passes into the tissues by absorption. They are first taken up by the absorbent vessels, and carried by them into the blood, and circulated by the blood through the whole body. They cannot pass into the cellular tissues of the stomach, except by means of these vessels and the bloodvessels. The vessels of the stomach might contain more in proportion than the blood in general circulation, but it would be pretty evenly diffused throughout the system. If two grains were found in the stomach, could not tell exactly how much there would be in the whole system. The stomach weighs about four ounces, and the blood, usually, about forty pounds. It would be a simple sum in proportion.

I have observed the effects of alcoholic liquor in *post-mortem* examinations. If the patient was taken sick in the night, called for rum, and fell into spasms and convulsions, which required two to hold him, and died between 10 and 11 the next forenoon, and the stomach was found reddened, and the muscles flaccid, there might have been various causes of death, such as apoplexy or inflammation of some organ. The appearances might be consistent with death from liquor, but would not prove it. Liquor produces convulsions, recurring until death, called rum-fits, between which

the patient is often conscious, though generally confused and trembling. If the person had been seen to be trembling and drunk before, it would indicate *delirium tremens*. These symptoms are not consistent with death by strychnia. The symptoms before, and the condition of the body after, death, seem to point to some other cause of death than strychnia.

English chemists have thus far been unable to detect strychnia after it has entered the blood. Have never known it to be done in my own experience. I heard Dr. Hayes's testimony. The methods he detailed were not the approved and usual ones. In the connection and order of experiments they differ from the methods which have been passed upon and approved by chemists.

Strychnia is difficult to detect; we are frequently unable to discover it where it is known to be present. I should not consider that brucia would render it essentially impure, as the latter is found in commercial strychnia. Many old tests have been abandoned. Nitric acid is an old test. It has since been discovered that it produces no coloration with strychnia, but does with brucia. Per-oxide of lead, as a test, was introduced about fifteen years ago. No one test is absolute, and unless each one is very characteristic it should be ruled out. At the best, the tests are merely cumulative evidence. A new test was discovered last year. New tests are used because the old ones were not entirely satisfactory. The tests already known, may be relied upon as inducing a strong belief; they do not amount to a demonstration. They are not so certain as those for mineral poisons, which can be detected beyond all doubt.

Most of the alkaloids have a bitter taste, some of them as bitter as strychnia. Rhombic prisms and rhombo-hedrons are entirely incompatible with four-sided square prisms. Octohedron and four-sided prisms are really of the same crystalline system, and are found in numerous other substances; quinia, morphia and codeia crystallize in same forms. The octohedron results from merely a shortening of the prism, the pyramidal terminations coming together.

If the symptoms before death and the appearances after, were characteristic, chemical analysis might be evidence of the existence of strychnia, and that death was caused by it, but a man may have poison in his stomach and still die from another cause.

The symptoms before death and appearances after, are together very reliable. I consider that, in this case, the two classes of evidence point in different directions.

A series of colors are produced by the color tests—blue, violet, red and reddish-brown. Unless all these appear in order, it is not a perfect test. Per-oxide of lead, bi-chromate of potash, oxide of manganese and ferro-cyanide of potassium, all produce the same colors. I should apply all the tests known. There are several tests not mentioned by Dr. Hayes; one of them is burning

of strychnia. It burns with a large, yellow flame and smoke, and all disappears.

Cross-Examined.—I consider that rigidity ought to be found as a *post-mortem* appearance. Dr. Taylor is good authority. He does not say that rigidity is always found. Distension of vessels of the brain is a most common appearance. Fluidity of blood is common.

The absorbents are small vessels that take up liquids and carry them into the circulation. They are very small, and exist all over the stomach. Strychnia passes through the absorbents into the circulation, and after its action the patient dies.

The stomach, after death, will take up liquids, like other dead membranes; is called cadaveric imbibition. If I had found strychnia, I should test it to be satisfied as to what it was. Crystals form better from some solvents than others. Sulphuric acid does not change the color of some alkaloids. I think codeia and quinia will not change colors. I am not confident about the concentrated acid. After the alkaloid is obtained, the action of strong sulphuric acid is a preparatory test. Then add bi-chromate of potash, we have blue and violet, passing to red color. I do not think chemical tests alone are absolutely reliable. I think there is such a thing as a demonstration by chemical analysis proving beyond a possible doubt. The steps spoken of would lead to a very strong belief. Should try all the tests known, in order.

There is a new test, discovered within a year—the perchloride of antimony. It first became known to me about six months ago, in the *Journal of Pharmacy*. I have never tried it; it is described as being exceedingly delicate.

I have seen Dr. Wormly quoted. I never have seen any book of his. As to blood in left ventricle, Dr. Taylor's opinion is that the condition of the heart is no evidence as to whether the death is caused by strychnia or not.

Know of no process recognized as Otto's. *Stas* differs a little from Flandin by using tartaric acid. I thought the use of caustic lime in the analysis of animal solids containing strychnia, belonged to Dr. Green. I don't think strychnia has ever been discovered in the tissues.

I was in Europe in 1829—from that to 1832. Strychnia was discovered in 1826. Experiments on animals had then been made. I don't know that any man had been poisoned by strychnia at that time. I have studied chemistry from fifteen years of age to the present time, and attended lectures in this country and in Europe. Have worked in my own laboratory. I originally pursued the practice of medicine; mineralogy and chemistry have taken the place of it. Chemistry is my principal business. Have been away, examining mines, during several seasons; have made geological surveys in different States.

If strychnia is in feathery crystals, two grains would be less than a third of a teaspoonful. I spoke of its bulk to Mr. Met-

calf, and he weighed it to satisfy himself, and was surprised at its bulk. I have not stated it was nearly a spoonful. I have no personal experience of fatal cases of poisoning by strychnia. I have never extracted strychnia from the human stomach. Have searched a good many for it, but have never found any yet. I speak from my special study of poisons.

Cod-liver oil, with concentrated sulphuric acid, will give precisely the same color as strychnia does with sulphuric acid and bichromate of potash. Bile, cod-liver oil and sulphuric acid, give red color. Strychnia is administered as a medicine in very minute doses, increasing them gradually.—Fluidity of the blood and congestion of the brain are very common in cases of sudden death. I have been engaged as chemist for the United States government. I don't expect to find cod-liver oil in the form of crystals. Oil of vitriol would discolor it. The crystals of strychnia, when pure, are white or nearly so. The whole mass of the blood would not contain the same proportional amount of poison as the absorbents and vessels of the stomach. There might be more in the absorbents.

Re-called.—I have had a very extensive experience in examining human stomachs for poison—some forty in all, and twelve within the last year. The shortest time I should require in a case of strychnia poisoning would be ten days.

(To be continued.)

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON: THURSDAY, APRIL 25, 1861.

DECEASE OF N. I. BOWDITCH, ESQ.—This sad, although not unexpected event, which occurred on the 16th inst., touches so many hearts in our community, that we cannot refrain from putting upon record at this time, when the departure of every good man from among us is doubly felt, our sense of the loss which this city has sustained, and our deep sympathy with those whom the sundering of the most tender family ties calls to be no common mourners. We do not propose to enter upon any biographical notice of Mr. Bowditch—that would be out of place here—but merely to speak of some of those traits of character which brought him more or less into relation with our profession, or those who are the special subjects of its care. The most prominent characteristics of Mr. Bowditch may be said to have been perfect honesty, simplicity and integrity, together with a strong love of justice, inflexible uprightness and unstinted benevolence. These were united with a most untiring diligence in the pursuit of all honorable objects in which he became interested. There was a transparent truthfulness and conscientiousness about him which charmed all hearts. His manner was peculiarly winning and gentle. Who that has once listened to the silvery and musical tones of his voice can ever forget their sweetness? The expression of his finely-modelled face was singularly kind and benevolent. There was not a look in it which could repel the most humble applicant for sympathy or aid. With all his gentleness of manner, there was no want of the most entire manly energy and decision. His ready sympathy with all good objects called forth the most prompt and efficient

action. When he felt interested, he spoke out plainly and unhesitatingly. His whole air was expressive of a straightforward manliness.

It has been our privilege for some years to know Mr. Bowditch, especially in his relations to the Massachusetts General Hospital, of which he was for many years one of the most devoted officers, having served as Secretary, Trustee, Chairman of the Board, and latterly as Vice President of that Institution. There are hundreds of patients that have enjoyed the privileges of the Hospital who will bear him always in the most grateful remembrance. His visits to its wards were not limited to those days when his official duties made it incumbent upon him to be there, but hardly a day passed, when he was in town, that did not see him wending his way in that direction. These visits were usually made in the afternoon, when he had the fullest opportunity for unrestrained intercourse with the patients, and they were looked for on their part as one of their choicest privileges. He took special interest in the personal wants and sorrows of the sufferers about him, and made them feel that he came as a personal friend. Any one meeting him in the vicinity of the Hospital would generally be attracted by the beautiful flowers which he carried, and a visitor to the wards would almost always see these tokens of his kindness on the little tables by the bedside of the sick—gifts which none perhaps appreciate so well as they. Throughout the season of fruits, a daily and most liberal gift of the choicest in the market was sent to the Hospital by Mr. Bowditch, to be distributed among the patients. Nor did his gifts stop here. He was sure to learn if any one leaving the Institution was in any great pecuniary strait, and his hand was ever ready to relieve such a want. Even after patients had left the Institution, we have known acts of his beneficence to those whom he had only been acquainted with as its inmates, and who could present no claims to his regard but the simple fact of their necessity. Delicacy prevents our alluding to a special instance of his benevolence thus worthily exercised, which came under our particular observation—doubtless there are many such, known only to the objects of them and the Omniscient Ruler of the Universe, for there was no ostentation in his charity.

In his relations to the medical profession, particularly as a Hospital officer, Mr. Bowditch was characterized by a most liberal and honorable spirit. He appreciated most fully the genius, so to speak, of the profession. There was no narrowness about him. He was ever ready to second any plan for the carrying out, to the fullest extent, such measures as the Board of Physicians and Surgeons deemed expedient for accomplishing the objects of the Institution. And without undervaluing the great services of the many gentlemen who have served in the same capacity, in its government, we may safely say, that no Trustee has ever done more than he to build it up and sustain it, and give it the honorable place which it now holds. In his decease, Boston has lost one of its brightest ornaments, but his example is one which will not soon be forgotten. The following resolutions were passed at a meeting of the Trustees of the Massachusetts General Hospital, held on the 17th inst., on the announcement of his death:—

Resolved, That the Board of Trustees of the Massachusetts General Hospital have heard with unfeigned sorrow of the decease, on yesterday evening, of Nathaniel Ingersoll Bowditch, Esquire, its respected Vice President.

Resolved, That his long connection with this Institution as Secretary, Trustee, Chairman of the Board and Vice President, extending through a period of thirty-five years; the untiring devotion of all the faculties of his mind and heart to the promotion of its interests; his fidelity, intelligence, ability, patience and firmness in the discharge of duty; his gentle, joyous and modest demeanor, at all times and under all circumstances, so peculiarly remarkable in him; his sympathy with suffering and his many noble and generous acts for its alleviation, so characteristically performed, and so beneficial and grateful to those who were the subjects of them; in short his whole character, moral and intellectual—constantly developing and maturing—and his whole life—always growing wiser and nobler and more useful to the last—have won for him the respect, admiration and love of all the members of the successive Boards of Trustees of this Corporation, and of the Physicians and Surgeons and other officers who from time to time have been connected with it, and demand from us this tribute of regard for his memory.

Resolved, That this Board, as a mark of respect for the character and services of its late Vice President, will attend his funeral in a body, provided the same be in accordance with the feelings of his family.

Resolved, That we sympathise deeply with the family of our deceased friend in the severe dispensation of Providence which has fallen upon them, and respectfully tender to them this token of our sorrow and regard.

Resolved, That the above resolutions be entered on the Records, and a certified copy of them transmitted to the family of the deceased.

Weekly Medical Journalism.—In the last number of the *Medical and Surgical Reporter*, a weekly Medical Journal published in Philadelphia, is a clever

editorial on the influence of journalism on medical progress, which, in the main, we fully endorse. In allusion to the history of medical periodical literature, in this country, however, we beg to correct the statement, that until quite recently the profession of our country has only had this species of literature in the quarterly, bi-monthly and monthly forms. So long ago as the year 1823, the first weekly Medical Journal was commenced in Boston, styled the BOSTON MEDICAL INTELLIGENCER; and in 1828, was issued the first number of this JOURNAL, which has continued uninterruptedly to the present time. It is gratifying to the friends of medical advancement, that our sister cities, even at this late date, have copied our example, and that both New York and Philadelphia now can boast of at least one creditable weekly medical periodical. We sincerely hope that the wide-spread influence they must necessarily exert, may, as we cannot doubt it will be, for the extension of the principles of sound medical learning, and they may thus prove "the conservators of medical opinion and progress." All matters of an historical nature, however trivial and unimportant in themselves, if recorded at all, should be recorded correctly, and it has been solely to this end that we have alluded to what, under other circumstances, we should have passed by without comment.

BOSTON DISPENSARY.—The following is a summary of the number of patients treated at the Boston Dispensary for the six months ending April 1, 1861:—

Whole number during the six months, 6,821. Central Office, 3,068. Medical service, 1,874—Males, 459; females, 759; children under fifteen, 617. Surgical service, 1,194—Males, 422; females, 337; children under fifteen, 435. Patients at their homes—whole number during the quarter, 3,753—Males, 637; females, 1,433; children, 1,683. Discharged cured or relieved, 3,499. Removed to Hospital, 96. Died, 117. Number of prescriptions dispensed, 17,688. Central Office, 8,328; District Physicians, 9,360. Average cost of each prescription, four cents.

LONG INCUBATION OF VACCINATION.—A correspondent writes to us:—"One year and a half ago, I vaccinated a little grandchild of mine, six months old. It did not work, and the three incisions made, rapidly healed up. She has never been vaccinated since; but about five months ago, all three places became sore, and she had the true vaccine pock. Her father vaccinated several children from her, and it worked well in every case. I saw the child last week, and found the well-marked, characteristic cicatrices."—*Med. and Surg. Reporter.*

ALTHOUGH we have not much faith in medical legislation in this country, owing to the instability of the enactments of State Legislatures, we still welcome any successful effort to throw around the people legal safeguards against the impositions of quacks. The Louisiana Legislature, through the influence of Dr. J. H. Stevens, has recently passed "an act relative to practitioners of medicine," which forbids any one practising medicine in that State, without making affidavit before a Justice of the Peace, that he has received a degree of Doctor of Medicine from a regularly incorporated medical institution in America or Europe. The affidavit is to be recorded by the Parish Recorder; any person practising without having made such affidavit, is not permitted to collect fees, and is liable to a penalty of $20.—*Am. Medical Times.*

REVACCINATION.—The Report of the National Vaccine Board for the year 1860 has been presented to the Privy Council. The Board have no evidence whatever that the frequent repetition of vaccination is necessary or even desirable; but they state that many facts tend to render it not improbable that vaccination performed in infancy may lose its protective power after adolescence. On these grounds, they add, revaccination at an early adult age would appear desirable. The Board supplied 219,490 charges of lymph in the course of the year.—*London Lancet.*

DEATH OF AN AGED ENGLISH OBSTETRICIAN.—Charles Earle, Esq., died recently at Norfolk, Eng., aged 84, having been in practice for 60 years. "As an obstetrician, Mr. Earle was most successful, and enjoyed a very extensive practice. In the *Journal* of the Provincial Medical and Surgical Association for

1846, he published a "Report of Obstetric Cases occurring in Private Practice" during a period of forty-six years; 4,320 cases are recorded, 17 of which alone proved fatal. He always had a great aversion to the use of instruments (although most dexterous in their application), and never resorted to them until convinced that nature's efforts were unavailing."

A BOARD of Medical Officers, to consist of Surgeons C. A. Finley, C. McDougall, and W. J. Sloan, has been ordered to assemble in New York City on the 1st of May, or as soon thereafter as practicable, for the examination of assistant surgeons for promotion, and of such candidates for appointment as may be invited to present themselves before the Board.——Dr. Wm. V. Keating has been elected Professor of Obstetrics in Jefferson Medical College, to fill the chair recently vacated by the resignation of Dr. C. D. Meigs.

VITAL STATISTICS OF BOSTON.

FOR THE WEEK ENDING SATURDAY, APRIL 20th, 1861.

DEATHS.

	Males.	*Females*	*Total.*
Deaths during the week,	37	33	70
Average Mortality of the corresponding weeks of the ten years, 1851-1861,	39.7	39.2	78.9
Average corrected to increased population,	..	..	88.65
Deaths of persons above 90,	1	1	2

Mortality from Prevailing Diseases.

Phthisis.	Croup.	Scar. Fev.	Pneumonia.	Measles.	Variola.	Dysentery.	Typ. Fev.	Diphtheria.
18	0	3	3	0	0	0	0	4

METEOROLOGY.

From Observations taken at the Observatory of Harvard College.

Mean height of Barometer,	29.698	Highest point of Thermometer,	62°
Highest point of Barometer,	30.064	Lowest point of Thermometer,	32°
Lowest point of Barometer,	29.100	General direction of Wind,	W. & N.E.
Mean Temperature,	45°.43	Am't of Rain (in inches) melted snow	3.110

From Observations taken by Dr. Ignatius Langer, at Davenport, Scott Co., Iowa. Latitude, 41.31 *North. Longitude,* 13.41 *West. Height above the Sea,* 585.

		BAROMETER.						THERMOMETER.				SNOW & RAIN.		Mean Amount of Cloud. 0 to 10.
		7 A.M.	2 P.M.	9 P.M.	Mean Height,	Highest Point,	Lowest Point,	7 AM	2 PM	9 PM	Mean Height,	Time	Measure.	
Monday,	April 8,	29.3	29.18	29.14				41	48	47				
Tuesday,	" 9,	29.18	29.22	29.33				45	51	47				
Wednesday,	" 10,	29.39	29.41	29.42				44	52	49				
Thursday,	" 11,	29.32	29.24	29.16	29.275	29.55	29.03	47	54	48	48	1 hour, 15 minutes.	0.10	9.3
Friday,	" 12,	29.13	29.8	29.12				50	56	49				
Saturday,	" 13,	29.20	29.27	29.39				46	51	44				
Sunday,	" 14,	29.51	29.55	29.51				37	56	48				

REMARKS.—The most cloudy week for more than a year, with little rain and with a barometer standing at a low point. *Prevalent Diseases.*—Irritation of the *urinary system*, especially the kidneys, *still* prevailing. The latest chlorate of potasa catastrophe has bridled that hobby for good, as, previously, it was difficult to separate here, the symptoms of the disease from those of the injudicious use of that otherwise useful remedy.

ERRATA.—Page 237, line 1, for "aged 57," read *aged* 37. Page 238, 25th line, for "for further delay. With a view," &c., read *for further delay with a view*, &c.

PAMPHLETS RECEIVED.—Sixth Annual Report on the Births, Marriages and Deaths in the city of Providence, for the year 1860, &c. By Edwin M. Snow, M.D., Superintendent of Health and City Registrar. (From the Author.)

MARRIED,—In this city, 18th inst., Moses Williams Weld, M.D., to Eliza G., daughter of the late Moses Everett.

DEATHS IN BOSTON for the week ending Saturday noon, April 20th, 70. Males, 37—Females, 33.—Accident, 1—apoplexy, 2—aneurism of the aorta, 1—imperforate anus, 1—congestion of the brain, 1—disease of the brain, 1—bronchitis, 1—cancer (of the chest), 1—cholera infantum, 1—consumption, 18—convulsions, 3—diphtheria, 4—dropsy of the brain, 3—erysipelas, 1—scarlet fever, 3—disease of the heart, 2—disease of the hip, 1—infantile disease, 1—influenza, 1—intemperance, 1—laryngitis, 1—disease of the liver, 2—congestion of the lungs, 2—inflammation of the lungs, 3—marasmus, 2—old age, 3—paralysis, 1—peritonitis, 1—pleurisy, 1—premature birth, 2—puerperal disease, 1—congenital obstruction of the rectum, 1—ulcers, 1—unknown, 1.

Under 5 years of age, 26—between 5 and 20 years, 6—between 20 and 40 years, 17—between 40 and 60 years, 15—above 60 years, 6. Born in the United States, 43—Ireland, 27.